Iowa Child Care Characteristics and Quality

Executive Summary

Midwest Child Care Research Consortium

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Executive Summary

The Midwest Child Care Research Consortium conducted a study of child care quality and characteristics of the child care work force in Iowa, Nebraska, Kansas, and Missouri. The purposes of this work were to help states establish a baseline for tracking 1) quality over time, 2) initiatives related to training, 3) policy and/or regulation changes, and 4) other changes in the child care system that may occur. The measures look beyond Iowa child care licensing standards. Rather, using research-based measures of quality, they assess the extent to which quality indicators are present among the child care settings and in the work force. The current study included a telephone survey of 2022 randomly selected Midwestern child care providers (408 from Iowa), conducted during late spring and summer of 2001 by the Gallup Organization, and follow-up in-depth observations of 365 providers (74 from Iowa), conducted by four Midwestern state universities. Several key findings from the study are highlighted in the sections below.

Research Questions

The initial set of questions that specifically addresses child care in Iowa is below. Each of these questions was proposed to become a baseline measure of some aspect of the child care system. These baseline measures are intended to enable comparison of quality measured at future points in time that may follow new and continued initiatives.

- What are the characteristics of the child care work force in Iowa and how do Iowa providers compare to those in the other three Midwestern states? How do provider characteristics vary according to type of care (i.e., infant/toddler or preschool center-based, family child care or approved license exempt care)?
- What is the quality of care in Iowa? How does child care quality vary according to different types of care?
- What is the quality of the childcare environment in Iowa in regard to providing experiences designed to nurture skills in early literacy, science and math, and early social interaction?
- What is the quality of interactions between providers and children in Iowa?
- Are quality and other features different between providers who care for children whose tuition is paid by government subsidies and those who do not? By those who receive a high proportion of payment by subsidy and a lesser proportion?
- Are there relationships between education, training, workplace characteristics, and selected practices of childcare providers and observed quality of care they provide for children?

Background

The child care workforce and child care quality have been studied over the past three decades. Nationwide, from 10% to 40% of child care is reported to be good quality (Cost, Quality and Child Outcomes Study Team, 1995). The policies that support child care quality, in Iowa and nationwide, are complex. In addition, the child care market generally does not support good quality or adequate wages for providers.

Methodology

The University of Nebraska's Center on Children Families and the Law and the Midwest Child Care Research Consortium contracted with The Gallup Organization of Princeton, New Jersey, and four state universities to conduct a study of child care workforce characteristics and quality in Iowa, Kansas, Missouri and Nebraska. A survey was developed based on indicators of child care quality and the child care workforce. These indicators were based on literature regarding child care services and information needs of state child care administrators. Names of approximately 10,000 providers were drawn from lists of nearly 40,000 regulated providers and subsidy-receiving clients in Iowa, Kansas, Missouri and Nebraska. The providers drawn were notified by letter that they could be called by Gallup to complete a 12-15 minute survey. Respondents were contacted between April and August of 2001; final survey sample size was 2022 (408 in Iowa). A subset of approximately 385 (74 from Iowa) providers was contacted for follow-up observations using well-known assessments of child care quality: the Infant-Toddler Environment Rating Scale (ITERS); the Early Childhood Environment Rating Scale-Revised (ECERS-R); the Family Day Care Rating Scale (FDCRS); and the Arnett Caregiver Interaction Scale which measures provider-child interactions. Reliability in observations was obtained across states and within states by "gold standard" observers who were "anchors" for their own states. The ITERS, ECERS-R, and FDCRS provide industry standard measures of child care quality and a score of "5" or above is defined as good quality and less than "3" is poor quality while the zone between "3"and "5" is defined as mediocre or minimal quality. In addition, two quality factors were created from self-reported quality practices; we refer to these as the Reading/Learning Centers factor and the Parent Communication Factor.

Definitions

The study was completed with several groups of child care providers, including: infant/toddler center-based providers, preschool center-based providers and family child care home providers. Within the scope of this study the category of family child care home providers may also have included group child care homes and group child care homes joint – registration (see definitions below). These definitions and descriptions of services in Iowa were current during the time of the study. Impending changes in child care registration guidelines are expected for Spring of 2003.

Licensing vs. Registration

In Iowa, "licensing" and "registration" are different. Center-based programs are licensed and home-based child care is registered. In both processes, the Department of Human Services establishes minimum requirements. Licensing requirements are more stringent. Licensing also requires a visit to the facility and an evaluation by a professional staff person before the license is issued. Licensed centers receive at least one annual visit by an Iowa Department of Human Services child care licensing consultant.

The registration process is less stringent. Family home providers self-certify in writing that they meet the minimum requirements in all areas of child care home operation. Responsibility for making sure the requirements are met rests primarily with the provider, the parents of children in care, and the community. Iowa Department of

Human Services reports that twenty percent of all registered child care homes are visited annually by a child care licensing consultant.

Family child care home registration is **voluntary.** A family child care home may register with the Iowa Department of Human Services, but is not required to do so. However, Iowa law limits the number of children a home may care for, whether the home is registered or not. A non-registered family child care home may not care for more children than a registered family child care home. Registration is **mandatory** for "group child care homes" and "group child care homes-joint registration." Registration must be renewed annually.

Types of Care

Infant /toddler center-based providers**:** Licensed center-based providers who care for children from 2 weeks to age 2. Child care licensing consultants make a minimum of one unannounced visit to center-based facilities each year.

Preschool center-based providers**:** Licensed center-based providers who care for children from age 2 to kindergarten age. Child care licensing consultants make a minimum of one unannounced visit to center-based facilities each year. Iowa state code defines a preschool center as a program which provides care to children ages three through five, for periods of time not exceeding three hours per day. However, for purposes of this study, "preschool center-based care" is defined as full-day care for "preschool-age" children ages three through five.

Family Child Care Homes: a program which provides child care to no more than 6 children at any one time, including the providers, own preschool age children. However, a registered or unregistered family child care home may provide care for more than 6 but less than 12 children at any one time for a period of less than two hours, provided that each child in excess of 6 children is attending school in kindergarten or a higher grade level. The provider's own children attending kindergarten or a higher level are not included in the total count. There can be no more than 4 children under the age of two years at any one time.

Group Child Care Homes: a program which provides child care to no more than 6 preschool age children at anyone time, including the provider's own children not attending kindergarten. A group child care home provider may also provide care for more than 6, but fewer than 12 children at any one time, provided that each child in excess of 6 children is attending school in kindergarten or a higher grade level, and there is an assistant (14 years or older) in the home to assist in the care of children when any child in excess of 6 is provided care for longer than two hours.

In addition to the above numbers, a registered group child care home may provide child care for more than 11 but fewer than 16 children for a period of less than two hours at any time. The provider's own children attending kindergarten or a higher grade level are not included in the total count. There can be no more than 4 children under the age of 24 months at any one time.

Group Child Care Homes -- Joint-Registration: a program that provides child care for more than 6, but less than 12 children. Of these no more than 4 children present may be less than 24 months of age. No more than 10 children present shall be 24 months of age or older, but not attending school in kindergarten or a higher grade level. The

combined total number of these two categories of children shall not exceed 11. In a joint registration group child care home, the joint holder for the certificate of registration must be an adult, and must meet the same requirements as those listed for the provider. In addition to the above numbers, a joint registration group child care home may provide care for more than 11 but less than 16 children for a period of less than two hours at any time.

Child Care Quality Ratings

The following terms are used to describe observed child care quality; these quality measures are derived from scales which are widely used in early childhood (see appendix C for more information):

Good quality care: Scores of "5" or higher on the Infant Toddler Environment Rating Scale (ITERS) (Harms, Cryer, & Clifford, 1990), the Early Childhood Environment Rating Scale-Revised (ECERS-R) (Harms, Clifford, & Cryer, 1998), or the Family Day Care Rating Scale (FDCRS) (Harms & Clifford, 1989)..

Mediocre or minimal quality care: Scores of "3" to "5" on the ITERS, ECERS-R or FDCRS are referred to as "mediocre or minimal" quality.

Poor quality care: Scores below "3" on the ITERS, ECERS-R or FDCRS are referred to as poor quality.

Key Findings

How does Iowa child care compare in quality with care in other Midwestern states?

The quality of full-day, full-year child care in infant care centers and in family child care homes in Iowa was significantly lower than the quality of child care in Kansas, Missouri, and Nebraska. Child care center programs for preschool-age children were comparable in quality to care in the other three states; however, the average quality of care for all types (infant, family home care and center care) in all four states fell in the mediocre range, as shown in Figure 1.

In a study by researchers at the University of Northern Iowa (Zan & Edmiaston, 2022), the quality of the Iowa Shared Visions classrooms, which are state funded, accredited preschools serving children at risk for academic failure, was much greater. This greater level of quality is attributed to several factors. Iowa Shared Vision Programs receive relatively stable funding support, have better educated staff, and must meet higher quality standards (i.e., NAECP accreditation).

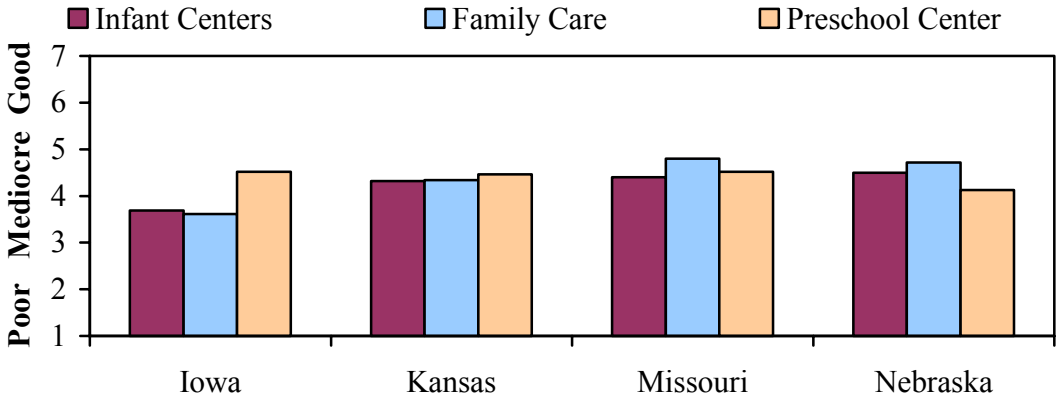

Figure 1. The quality of care in family child care home, infant centers, and preschool centers

Why is the quality of care important?

National studies (e.g., Peisner-Feinberg et al., 2001) have found that good quality child care predicted more advanced academic and social skills through the second grade, particularly for children of parents with lower levels of formal education. However, nearly 40% of the observed family child care homes in Iowa offered poor quality care, which puts children at risk not only for health and safety, but also for the learning, language, literacy, and social skills needed for success in school. Nearly 20% of the observed infant child care centers offered poor quality care; furthermore, none of the observed infant care centers were offering good quality care.

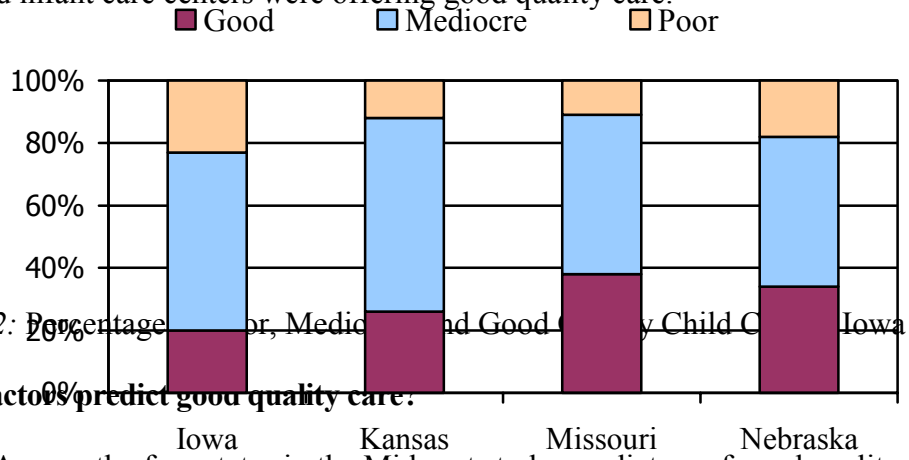

Figure 2: Percentage [illegible]or, Mediocre and Good [illegible]y Child C[illegible] Iowa

What factors predict good quality care?

Among the four states in the Midwest study, predictors of good quality care included:

- Formal education of the caregiver
- Level of training completed in the past year
- Participation in the USDA Child and Adult Care Food Program
- Completion of a professional credential in early care and education
- Accreditation by a national professional organization
- Higher caregiver salary and benefits

Across the nation, state and community initiatives that have provided support for increased salaries and benefits, increased access to high quality training and education, improved licensing standards, and higher expectations for accreditation have consistently shown increases in quality of care.

How does Iowa compare in factors related to quality?

In contrast to caregivers in other states, Iowa caregivers earned, on average, lower salaries for full-day, full year work ($12,200 per year); furthermore, Iowa caregivers had completed, on average, fewer training hours in the past year.

Compared with the other Midwestern states, Iowa has fewer full-time child care licensing specialists to monitor minimal standards relative to the number of licensed centers. Iowa has fewer regulations, less stringent regulations, and provides less on-site monitoring for family child care providers. Iowa is the only one of the four states in this study, and one of the few states in the nation, to provide no mandatory licensing for home providers caring for fewer than 13 children.

Iowa also has provided fewer state-wide training initiatives to increase quality; Iowa also has fewer collaborative efforts between child care programs and publicly operated, part-day programs such as Head Start or Shared Visions.

Why should Iowans be concerned about poor quality in child care?

Currently Iowa has the highest percentage of employed parents of young children in the nation (U.S. Census Bureau, 2002). A recent national report indicated that Iowa also has the second highest national rate of founded child abuse reports in child care settings (Scott, 2001, based on data from National Clearinghouse on Child Abuse and Neglect Information, 1999). The effects of poor quality care can be expected to show up in lower language, literacy, academic, and social skills in Iowa's kindergartens. These results may also influence the decisions of families and businesses to relocate to Iowa.

Recommendations

Iowa's early care and education system needs improvements in regulations, enforcement, and professional development. No parent should have to leave their child with a caregiver and wonder whether the provider will wash hands after changing a diaper and before fixing a meal. The high rate of founded child abuse in Iowa child care centers supports the need for such regulation. Although some would argue that this rate is high because Iowa does not distinguish between child care and babysitting, we would argue that the lack of distinction reflects Iowa's lack of child care regulation and enforcement. The absence of child care regulations does not provide parent choice, it limits parent choice because of the failure to provide consumer protection. The relatively high scores in caregiver interaction suggest that parents may be choosing care based on the interactions they observe and experience with the caregiver. However, consumer protection is needed to ensure that the caregiver implements basic health and safety regulations when the parent cannot be present.

Iowa's lack of regulations and enforcement may also result in the lack of impact on quality from specific training initiatives, such as Child Net. Using training to substitute for regulation and enforcement is costly and inefficient. Without regulations, a significant portion of training monies are devoted to motivating providers to participate in training, to improve practice from poor to at least mediocre levels, and to become registered.

Mandatory licensing, such as implemented in other states for group sizes over four children, may permit training efforts to focus on helping providers improve from mediocre to good quality practices. Mandatory licensing may also encourage more collaborative partnerships between Head Start and family child care providers. Furthermore, mandatory licensing will help persuade the poorest quality providers—those who provide child care only for the paycheck, or only to help someone, or until they get another job--to seek another profession. For both educational and economic reasons, more of Iowa's child care needs to be in the good quality category.

Although Iowa does have some preschool center-based child care programs that provide early care and education of good quality, it is especially troubling that no instances of good care were observed among infant-toddler center-based programs. Critical developments in social, cognitive, and communication skills occur through the very young child's interactions with the primary caregiver. Although some family child care was good quality, nearly half of the family child care was of poor quality. Good quality care leads to good outcomes for children and helps to provide the foundation needed for success both in school and in life. It is less costly to build social, cognitive, and communication competencies in qood quality early care and education than it is to remedy the social, cognitive, communication deficits when children are in elementary school.

Specific recommendations based on the findings of this report follow:

1. There is an immediate and urgent need to improve quality among infant-toddler center-based providers. A major training initiative, the Program for Infant-Toddler Caregivers, was begun after this data was collected. This program may help increase program quality. However, the high turnover, low wages, and poor scores in adult needs suggest that the administrative and supervisory infrastructure for infant child care also needs attention.
2. There is an immediate and urgent need to improve quality among both registered and non-registered family child care home providers who are approved to receive public subsidy dollars. Few non-registered providers were observed; however, the care observed in those settings was among the lowest quality care observed overall. On average, non-registered providers had lower levels of education; furthermore, they reported engaging in fewer quality related practices than other providers. If providers are to receive public subsidies, they should be required to meet basic health and safety standards.
3. Whenever possible, target family child care home providers when establishing relationships with Early Head Start/Head Start programs, increase access to opportunities for CDA training, and increase access to participation in the USDA Child and Adult Care Food Program. A combination of regulation, enforcement, and training initiatives will provide an investment in providers who choose child care as a profession and who intend to stay in the field. Prioritize CPR/First aid training for all providers to ensure the basic safety of Iowa children for whom the state provides child care funding.

4. Emphasize improvements in the learning opportunities available to children throughout Iowa child care. It is especially urgent to help infant-toddler center-based and family home providers see the potential for intentional planning, creative use of space, and other high quality early childhood practices.
5. Continue to work to raise the very low annual earnings and enhance work-related benefits among providers in every form of child care in the state.
6. Continue to augment partnerships between all early care and education providers in Iowa (e.g. Early Head Start/Head Start, Shared Visions, early childhood special education, and child care providers). Iowa has chosen to invest many of its early care and education funds through Empowerment Areas giving a great deal of control to local communities. However, Iowa has fewer examples of partnerships between Early Head Start/Head Start programs than is true for the other Midwestern states where these formal partnerships were strongly associated with higher levels of quality. In addition, quality in some programs within Iowa (e.g., Shared Visions programs) is higher than is the quality of Iowa child care settings overall.
7. Support local Empowerment Areas to implement initiatives directed toward quality improvements throughout Iowa's early care and education system. Further training regarding the components of quality; program design, administration, and evaluation; and collaboration could enhance these efforts effectively.
8. Continue and expand efforts to strengthen the rigor and enforcement of Iowa's child care regulations. Recent steps to strengthen Iowa's registration system for family child care home providers represent an important move in this direction. However, Iowa continues to have the least rigorous child care regulations among its Midwestern neighbors, and Iowa has the lowest ratio of personnel assigned to inspection relative to numbers of providers. Provide expanded training and educational opportunities, especially training opportunities that are rigorous and outcomes oriented.
    - Provide incentives for achieving performance outcomes from increased education and training.
    - Replace requirements for training from hours-based to outcomes-based, based on specific competencies in the Iowa Early Care and Education Professional Development Competencies.
    - Implement pre-service requirements for training to ensure that all caregivers have completed basic health and safety training *before* caring for children. Enforce requirements for CPR/First Aid training, especially among family home providers.
    - Explore avenues to embed the CDA within the two-year programs offered by community colleges to bring the added rigor of the CDA to two-year preparation and to bring Iowa up to CDA completion rates in neighboring states.
    - Build articulation systems from outcomes-based training provided by groups such as Child Care and Referral Agencies and Cooperative Extension to competency-based credentials, such as the CDA, and credit-based degrees at community and four-year colleges.

- Build on the contributions of the USDA Child and Adult Care Food Program that has been an important way to augment the quality of programs serving low-income children in neighboring Midwestern states.
- Combine Internet and video training programs with "in-person" training components. Iowa providers use "not in-person" training heavily, especially family home providers and providers living in rural areas. Unfortunately, the benefits of this type of training are not as great as those associated with "in-person" training. Consider more opportunities for "in-person" training for family child care (e.g., Missouri's EDUCARE program).
- Build on successful and promising approaches. For example, continue efforts with and expand upon ongoing training initiatives (e.g., PITC) that associate with quality across the country. Continue to emphasize training that has a monitored outcome, certificate, or credit.
- Provide training for providers to enhance their abilities and willingness to implement a curriculum or a planful approach to their caregiving. Such intentionality appears to be a strong correlate of quality across the Midwest and the nation.